The Commonwealth of Massachusetts
Department of Public Health
Office of Patient Protection
250 Washington Street, 1st Floor
Boston, MA 02108
Phone: 1-800-436-7757 Fax: 617-624-5046

This request must be filed with the Office of Patient Protection within 45 days of the patient's receipt of written notice of the final adverse determination.***** **If you plan to request an expedited review, please read pages 8-10 immediately.**

REQUEST FOR INDEPENDENT EXTERNAL REVIEW OF A HEALTH INSURANCE GRIEVANCE

PATIENT INFORMATION

1. Patient's Name:	
2. Patient's Date of Birth:	
3. Mailing Address:	
4. Telephone Number:	Daytime: (____) _____ Evening: (____) _____

INFORMATION ABOUT THE PATIENT'S HEALTH INSURANCE COVERAGE

5. Policyholder's Name:	
6. Patient's Insurance ID Number:	
7. Name of Health Insurance Company:	
8. Health Insurance Company Address:	
9. Person at Health Insurance Company Involved With Your Appeal:	
10. Do you have coverage with: (a) MassHealth (Medicaid)? (b) Medicare?	(a) Yes ☐ No ☐ (b) Yes ☐ No ☐

11. Describe the disagreement with your health plan and, if possible, indicate the services being denied. Attach additional pages if necessary. You must also attach any information you received from your health plan concerning the denial, and any additional information from your physician that you want the external reviewer to consider.

_____

_____

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APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this review.)

You can represent yourself, or may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

12. I hereby authorize _____ to pursue my external review on my behalf.

Signature of Patient (or legal representative)*_____Date_____
*(Parent, Guardian, Conservator, or Other – Please Specify on line below):
_____

Address of Authorized Representative:
_____
_____
_____

Phone Number: Daytime: (____)_____ Evening: (____)_____

INFORMATION ABOUT YOUR TREATING HEALTH CARE PROVIDER

13. Name of health care provider who ordered the service that is the subject of the dispute with your insurer:
_____

Type of Provider: ☐Physician ☐Other (please specify):_____
Provider Mailing Address:_____
_____
Provider Phone Number: (____)_____

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REQUEST FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS

The Office of Patient Protection (OPP) will randomly assign your case to one of the three agencies with which it has contracts for external review: The Center for Health Dispute Resolution (CHDR), the Island Peer Review Organization (IPRO) or Independent Medical Expert Consulting Services, Inc. (IMEDECS). This will authorize the release of medical records to the agency that will conduct the review. This authorization may be revoked at any time by writing to the Office of Patient Protection at the above address, but information previously released in reliance upon the authorization will not be affected by the revocation.

I _____ , hereby request an external review of the matter described on page 2 of this application. I attest that the information provided in this application is true and accurate to the best of my knowledge.

I authorize my HMO, health insurer or providers to release all relevant medical or treatment records related to the matter described in this request for external review to the external review agency named by the Office of Patient Protection to review my request. I understand that the external review agency will review my medical records to make its decision, and that without my authorization, the agency will be unable to review my request.

This release is valid for six months from _____ (today's date).

I understand that the external agency may not be covered by federal privacy laws. (Note, however, that according to 105 CMR 128.416, no external review agency or reviewer shall, except as specifically authorized by an appropriate release signed by a patient or representative authorized by law, release medical and treatment information or other information obtained as part of an external review, except to the Office of Patient Protection and as otherwise authorized or required by law.)

I understand that the Office of Patient Protection may not be covered by federal privacy laws, and that they may be able to further share the information that is given to them. (Note, however, that medical records are exempt from disclosure under the Massachusetts public records law (M.G.L. c. 4, § 7(26)(c)), and that the Office of Patient Protection will not share your records with anyone without your written permission.)

_____ Date:_____
Signature of Patient (or Legal Representative)*

*(Parent, Guardian, Conservator, or Other – Please Specify) :_____

Authorization form continues on page 4

Permission about Specific Health Information (Please put your initials if you are authorizing the release of any of the following information):

_____I specifically give permission, as required by M.G.L. c. 111, § 70F, to release information in my record about HIV antibody and antigen testing, and HIV/Aids diagnosis or HIV/Aids treatment, to the external review agency.

____I specifically give permission, as required by M.G.L. c. 111, §70G, to release information in my record about my genetic information to the external review agency.

____I specifically give permission to release information in my record about alcohol or drug treatment to the external review agency. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

_____ Date:_____

Signature of Patient (or Legal Representative)*

*(Parent, Guardian, Conservator, or Other – Please Specify) :_____

AUTHORIZATION TO REFER CASE TO ANOTHER STATE AGENCY

The Office of Patient Protection may wish to refer this case, including medical records released by this authorization, to the Massachusetts Division of Insurance or the Office of the Attorney General for further investigation and possible action against the insurer.

I understand that other state agencies may not be covered by federal privacy laws, and that they may be able to further share the information that is given to them. (Note, however, that medical records are exempt from disclosure under the Massachusetts public records law (M.G.L. c. 4, § 7(26)(c).)

Please check one of the following:

☐ I give my permission to the Office of Patient Protection to refer my case to the Division of Insurance or the Office of the Attorney General.

☐ I do not give my permission to the Office of Patient Protection to refer my case to another state agency.

☐ Please call me to discuss the referral of my case to another state agency. I understand that you will need my written permission to share medical information.

_____ _____

Signature of Patient (or Legal Representative)* Date

*(Parent, Guardian, Conservator, or Other – Please Specify) _____

DPH revised the authorization form contained on pages 3 and 4 of this application to meet the requirements for a valid authorization set forth in HIPAA (45 CFR 164.508(c)).

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Please note: Federal law requires this separate authorization form for the release of medical records that are psychotherapy notes. Complete this form only if you are requesting review of a claim for mental health services.

REQUEST FOR EXTERNAL REVIEW AND RELEASE OF PSYCHOTHERAPY NOTES

The Office of Patient Protection (OPP) will randomly assign your case to one of the three agencies with which it has contracts for external review: The Center for Health Dispute Resolution (CHDR), the Island Peer Review Organization (IPRO) or Independent Medical Expert Consulting Services, Inc. (IMEDECS). This will authorize the release of psychotherapy notes to the agency that will conduct the review. This authorization may be revoked at any time by writing to the Office of Patient Protection at the above address, but information previously released in reliance upon the authorization will not be affected by the revocation.

I _____ , hereby request an external review of the matter described on page 2 of this application.

I authorize my HMO, health insurer or providers to release all relevant psychotherapy notes related to the matter described in this request for external review to the external review agency named by the Office of Patient Protection to review my request. I understand that the external review agency will review my medical records to make its decision, and that without my authorization, the agency will be unable to review my request.

This release is valid for six months from _____ (today's date).

I understand that the external agency may not be covered by federal privacy laws. (Note, however, that according to 105 CMR 128.416, no external review agency or reviewer shall, except as specifically authorized by an appropriate release signed by a patient or representative authorized by law, release medical and treatment information or other information obtained as part of an external review, except to the Office of Patient Protection and as otherwise authorized or required by law.)

I understand that the Office of Patient Protection may not be covered by federal privacy laws, and that they may be able to further share the information that is given to them. (Note, however, that medical records are exempt from disclosure under the Massachusetts public records law (M.G.L. c. 4, § 7(26)(c)), and that the Office of Patient Protection will not share your records with anyone without your written permission.)

_____ Date:_____
Signature of Patient (or Legal Representative)*

*(Parent, Guardian, Conservator, or Other – Please Specify) :_____

DPH created this separate authorization form for release of psychotherapy notes to meet the requirements for a valid authorization set forth in HIPAA (45 CFR 164.508(c)).

INFORMATION ABOUT THE FEE FOR EXTERNAL REVIEW

Massachusetts law states that the patient seeking an external review is responsible for the first $25 of the cost of the review. The insurance company pays the remainder.

You must enclose a check or money order for $25 made out to the Commonwealth of Massachusetts.

☐ I have enclosed the check or money order for $25.

☐ I am requesting that the Office of Patient Protection pay the $25 fee because the payment of the fee would result in extreme financial hardship for me. Check one of the boxes below:

☐ My income is below 300% of (less than three times) the federal poverty level (see chart below).

2006 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.
1	$ 9,800
2	13,200
3	16,600
4	20,000
5	23,400
6	26,800
7	30,200
8	33,600
For each additional person, add	3,400

SOURCE: *Federal Register*, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849

☐ My income exceeds the guidelines but payment of the $25 would cause me extreme financial hardship because:

_____
_____
_____
_____
_____
_____
_____

Please note that you must demonstrate extreme financial hardship in order for OPP to pay the $25 fee for you.

WHAT TO SEND AND WHERE TO SEND IT

Please be sure your request includes **all** of the following:

- ☐ This completed application form.
- ☐ Your $25 share of the cost of the review.
- ☐ A copy of the final adverse determination***** from your health insurer.
- ☐ A photocopy of your insurance card or other evidence that you are insured by the health insurance company named in this application.
- ☐ Any medical records, statements from your treating health care providers, or other information that you would like the independent review agency to consider in reviewing your case.

If you need assistance in completing this form, or do not have one or more of the above items and would like information on alternative ways to complete your request, please call the Office of Patient Protection at 1-800-436-7757.

Mail the application to:

Office of Patient Protection
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Applications requesting an expedited review should also be faxed to the Office of Patient Protection at 1-617-624-5046. After faxing your expedited external review request, please call 1-800-436-7757 to advise the Office of Patient Protection that a request has been faxed.

The Office of Patient Protection will screen your request to verify that all information is complete, that your request relates to a final adverse determination from a health insurer, and that the requested service is not specifically excluded from coverage in your health plan evidence of coverage. If your case is eligible, it will be sent to one of the independent review agencies under contract with the Department of Public Health. By law, the external review agency must complete its review within five business days for expedited requests and 60 business days[1] for all other requests. If you have any questions about the review process, please call the Office of Patient Protection at 1-800-436-7757.

***A *final adverse determination** is the written notice from your health insurer telling you:*

- *that your claim is being denied based on medical necessity, appropriateness of health care setting and level of care, or effectiveness of treatment, and*
- *that you have exhausted the insurer's internal appeals process.*

This completes the application process unless you are requesting an expedited review. If you are requesting an expedited review, please also complete and return pages 8-10.

[1] The external review agency may extend the 60-day period by 15 additional business days when necessary. If this is the case, you will be notified.

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REQUESTS FOR EXPEDITED REVIEW

Massachusetts law permits a patient to request an expedited external review in the event of a serious and immediate threat to the patient's health. Any request for an expedited external review must contain a certification, in writing, from your physician (MD or DO) that delay in the provision or continuation of health care services that are the subject of a final adverse determination would pose a serious and immediate threat to the health of the patient.

If this is a request for an Expedited Review, a physician must complete pages 9 and 10, labeled "Physician Certification for Expedited External Review." You must provide the form to your physician, and the physician must fax the completed form to the Office of Patient Protection.

I sent the form to my physician. Please check one:

☐ By Mail ☐ By Fax ☐ Other (describe) _____

☐ I did not send the form to the physician. (Please explain):

Name of Physician:	
Address:	
Telephone Number:	(____)_____

REQUEST TO HAVE COVERAGE CONTINUE DURING THE EXTERNAL REVIEW

Massachusetts law states that if the subject matter of the external review involves the termination of ongoing services, the patient may apply to the external review agency to seek the continuation of coverage for the terminated service during the period the review is pending. **Any such request must be made before the end of the second business day following receipt of the final adverse determination from the insurer.** The review agency may order the continuation of coverage or treatment where it determines that substantial harm to the patient's health may result if the coverage or treatment is not continued or for other good cause as the review agency determines. Any such continuation of coverage will be at the insurer's expense regardless of the final external review determination.

☐ I am requesting continuation of services that were previously authorized by the insurer.

_____ _____
Signature of Patient or Authorized Representative Date

Physician Certification for Expedited External Review

A patient or the patient's authorized representative, if any, may request an expedited external review if the physician who ordered the services certifies that delay in the provision or continuation of health care services that are the subject of a final adverse determination would pose a serious and immediate threat to the health of the patient.

The physician must complete this certificate and immediately fax it to the Office of Patient Protection at 1-617-624-5046 in order for a patient to be eligible for an expedited external review of a medical necessity determination.

Name of Patient: _____

Patient's Phone Number: _____

Patient's Health Plan Member ID Number: _____

Name of Physician completing this form: _____

Address: _____
_____
_____

Contact Person: _____

Phone Number: ( )_____
Fax Number: ( )_____

An expedited decision is necessary because a delay in providing the recommended health service would pose a serious and immediate threat to the health of the patient.

_____ YES _____ NO

Continued on next page

If yes, explain the nature of the serious and immediate threat to the health of the patient:

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

_____
Physician's Name

_____
Signature

_____
Date

Physician's Office Stamp:

Fax this completed certificate to 1-617-624-5046

If you have any questions, please call the Office of Patient Protection at 1-800-436-7757.